SHINGLES (ZOSTER / HERPES ZOSTER)

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Reactivation of a person's latent (hidden) varicella zoster virus, the virus which causes chickenpox, can result in "shingles", sometimes called "zoster" or "herpes zoster".
- Contact with a person who has shingles may cause chickenpox in a non-immune individual.
- Both **localised** and **disseminated** shingles may be transmitted by airborne spread and/or direct contact and result in chickenpox in a susceptible person; however, **disseminated** shingles is more contagious.
- Standard and Contact transmission-based precautions apply for cases of **localised** shingles.
- Standard, Contact and Airborne transmission-based precautions apply for cases of **disseminated** shingles
- Children with **localised** shingles may be nursed in a single room on any ward **except**
  - At CHW: Camperdown, Clancy and Edgar Stephen.
  - At SCH: C2West, C2North
- Children with **disseminated** shingles must be nursed in a N class (negative pressure) or 100% exhaust ventilation room.
- Non-immune Health Care Workers should not have contact with patients with disseminated shingles.
- All workers should be screened and those non-immune will have a risk management plan in place. Non–immune Health Care Workers who are exposed to shingles must inform Infection Prevention and Control and be followed-up by Staff Health.
- Health Care Workers who are infected with shingles may be able to continue to work if the lesions can be completely covered. This should be discussed with Infection Prevention and Control.

This document contains information relevant to current Wards/Units as well as information for wards moving into the new build. Staff should follow this document according to the Ward/Unit location (i.e. current or new-build Ward/Unit).

Approved by	SCHN Policy, Procedure and Guideline Committee	
Date effective:	1st April 2025	**Review Period:** 3 years
Team Leader	CNC	**Area/Dept:** Infection Prevention & Control

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CHANGE SUMMARY

- Changed scope from CHW-only to SCHN.
- Minor changes made throughout the document. Recommend for staff to re-read the entire document.
- Updated terminology

READ ACKNOWLEDGEMENT

- Medical & Nursing staff working in clinical areas are to read and acknowledge they understand the contents of this policy.
- Infection Prevention and Control team and Staff Health are to read and acknowledge they understand the contents of this policy.

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Introduction

Aetiology

Following infection with varicella-zoster virus (VZV) which causes chickenpox, the virus remains in the body for life and becomes latent (hidden) in nerves that supply sensation to the skin. Normally the varicella virus remains latent (aided by the body's natural immune system) but if the immune system is weakened, reactivation can occur. Reactivation of the virus can result in "shingles", sometimes called "zoster" or "herpes zoster". It cannot be triggered by contact with someone who has chicken pox.

Clinical Manifestations

The first sign of shingles is usually a tingling feeling or itchiness of the skin, which can occur up to one week before the rash occurs. Grouped vesicular lesions appear in the distribution of one to three sensory dermatomes, usually the forehead and scalp, the chest or abdomen, sometimes accompanied by severe localised pain. Systemic symptoms are usually minimal. After several days, the lesions become fluid-filled blisters which dry out and crust within two weeks. Dry, crusted lesions are no longer infectious. A typical episode of shingles lasts 1-2 weeks. It is rare for children to develop post-herpetic neuralgia, but in adults, neuropathic pain can continue for months or years after shingles.

Shingles occasionally becomes disseminated in immunocompromised persons, with lesions appearing outside the primary dermatomes with or without visceral complications.

Mode of Transmission

- Cases of both localised and disseminated shingles are infectious and can be passed on by direct contact, or airborne spread causing chickenpox in people who are not already immune.
- Disseminated shingles is highly infectious and is thus readily transmissible to a susceptible person.
- Although airborne transmission of VZV can occur from immunocompetent individuals with localised shingles, the risk is much lower than for chickenpox or disseminated zoster. In most cases of localised shingles this risk can be managed without requiring negative pressure isolation.

Period of Transmissibility

The period of transmissibility persists until all lesions are crusted, usually 1-2 weeks. Immunocompromised children can remain infectious for longer.

Risk of Acquisition

Shingles generally affects young and/or immunodeficient children, although anyone who has previously had chickenpox can get shingles. Contact with a person with shingles can cause chickenpox (but not shingles) in someone who has never had chickenpox before or has not received the varicella vaccine.

Command and Control

Responsibility for implementation of this policy is the direct responsibility of appropriate clinical line managers caring for affected patients.

- The clinical line Managers will consult with the Infection Prevention and Control Team regarding appropriate patient placement and infection control procedures.
- Decisions related to isolation and transmission-based precautions for emerging infections are difficult when there is a lack of clinical evidence. Decision making is often pragmatic and can lead to dispute between clinical line Managers and Infection Prevention and Control / Microbiology
- If there is no policy on a particular issue or the policy needs updating then there needs to be further discussion between clinical line managers, Infection Prevention and Control, Microbiology and the site Director of Clinical Operations to develop a consensus agreement based on best evidence. If a dispute arises about policy, it is to be referred to the Executive Director of Clinical Operations (CO) for resolution.
- Shingles is not mandated as a reportable infection to Public Health Units.
- A Reportable Incident Brief (RIB) will be sent to NSW Department of Health on any potential media interests or problems. This is currently the responsibility of the Executive Assistant to the CO.

Infection Control Measures

In a case of immunocompetent patients with localised shingles Standard and Contact transmission-based precautions apply.

In a case of immunocompromised or disseminated shingles Standard, Contact and Airborne transmission-based precautions apply.

Management

Patients

The Immunocompetent Child

Immunocompetent children with shingles may be nursed on any ward with a few exceptions (See Table 1) in either a single room or cohorted with other children with shingles or chickenpox. Standard and Contact transmission-based precautions apply until all vesicles are dry and crusted, usually within 1-2 weeks. Lesions should be covered, if possible, using a hydrocolloid dressing (examples include Comfeel Plus, Duoderm, Granuflex, Ultec, and 3M Tegaderm Hydrocolloid).

The Immunocompromised Child

Immunocompromised children who have either localised or disseminated shingles and any other child with disseminated shingles must be nursed in an N class (negative pressure) room or 100% exhaust ventilation room. Standard and Airborne transmission-based precautions apply for the duration of the illness. Lesions should be covered, if possible, with a hydrocolloid dressing.

Exposed Patients

Immunocompromised and non-immune children are at risk of developing chicken pox following exposure to a patient or health care worker (HCW) with active shingles. The risk depends on the immune status of the exposed child and the degree of contact. Refer to the Varicella (Chicken pox) policy for further details on post-exposure prophylaxis and isolation requirements.

Table 1 – Immunocompetent Patients – NOT to be placed on the following wards

CHW Wards	SCH Wards
Camperdown Ward	C2West
Clancy Ward	C2North
Edgar Stephen Ward	

Contact IPC/ID to discuss a risk management plan if patient requires specialty treatment/care only available in the wards tabled.

Staff

Health Care Workers (HCW) without evidence of immunity to VZV (especially those who are pregnant) should not care for, or have direct contact with, children infected with shingles. However, HCW with a clear history of chickenpox, serological evidence of immunity to varicella zoster or documentation of varicella vaccination may care for these patients. All HCW that are non-immune should have a risk management plan in place discussed with Staff Health.

Exposed Health Care Workers

Susceptible HCW exposed to chickenpox or shingles during the course of their work will be assessed by Staff Health during the course of the incubation period and excluded from taking care of high-risk patients. Vaccination should be offered. Refer to the Varicella (Chicken pox) policy for further details on post-exposure prophylaxis and isolation requirements.

Infected Health Care Workers

HCW with shingles must inform Infection Prevention and Control (IPC) and Staff Health. These personnel must be excluded from working in the Wards/Units listed in Table 2 until all lesions are crusted and no new lesions appear within a 24-hour period.

HCW may work in all other areas (following discussions with IPC) but should not care for or attend immunocompromised patients or neonates. The shingles lesions must be covered with a hydrocolloid dressing (examples include Comfeel Plus, Duoderm, Granuflex, Ultec, and 3M Tegaderm Hydrocolloid) and HCW must adhere to strict hand hygiene practices. If lesions cannot be adequately covered, staff may be asked not to come to work until lesions have crusted.

Table 2 – Staff with shingles must NOT work in the following Wards

CHW	SCH
Intensive Care and Close Observation Units	Intensive Care unit
Clancy Ward	C2 West
Edgar Stephens Ward	C2 North
Camperdown Ward	C1 North
Clubbe Ward	
Turner Day Stay	

Parent/Carer

If a parent/carer develops shingles while providing care to their child in hospital, ward staff are to contact IPC to discuss exposure risk of the patient/s and staff to determine the appropriate management strategies.

Recommendations include lesions should be covered, avoid touching or scratching the lesions/rash and avoid attending common areas including Starlight Room. Encourage regular hand hygiene practice. Parent/Carer may be advised to attend a local medical centre for antiviral therapy. If a parent has disseminated shingles, they may be asked to go home or they may have to remain in an N class (negative pressure) room or 100% exhaust ventilation room. Parent/carer should not attend food and beverage outlets.

Visitors and Siblings

Inpatients with shingles must have their visitors restricted to those who are immune to varicella. Thorough hand washing is required on entering and leaving the room.

Equipment and Environment

- The child's room must be thoroughly cleaned with a neutral detergent after the child has vacated the room (discharge or transfer).
- If the child is relocated, all equipment, if possible, should be moved with the child to the new location. Equipment should not be shared with other children.
- If equipment is required to be used for other children, it must be adequately cleaned by wiping over with detergent-disinfectant impregnated wipes.
- No special handling of linen is required.
- Avoid other children being admitted to the room vacated by a patient with active shingles for at least 30 minutes after the child has vacated the area and the area has been cleaned.

Factsheets

- NSW Health **Fact Sheet Chickenpox**: https://www.health.nsw.gov.au/Infectious/factsheets/Pages/chickenpox.aspx
- NSW Health **Fact Sheet Shingles**: https://www.health.nsw.gov.au/Infectious/factsheets/Pages/shingles.aspx

References

1. American Academy of Paediatrics. Varicella Zoster Viral Infections. In Kimberlin DW, Barnett Ed, Lynfield R, Sawyer MH, eds. *Red Book 2021: Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Paediatrics; 2021: 831-842.
2. National Health and Medical Research Council (2024): Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: Commonwealth of Australia. Guideline Australian Guidelines for the Prevention and Control of Infection in Healthcare (V11.25) sited 14/01/2025.
3. National Health & Medical Research Council. Varicella Zoster. *The Australian Immunisation Handbook*.. Commonwealth of Australia; 2024: Varicella (chickenpox) | The Australian Immunisation Handbook.sited 14/01/2025.
4. NSW Health Policy Directive PD2024_015 "Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases. 2024 Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases
5. Dept of Health and Aged Care (2022) Shingles www.health.gov.au/diseases/shingles#about-shingles

Isolation information

Shingles – Information for Patient / Parent while an inpatient:

- Standard and Contact precautions apply for cases of **localised** shingles until all lesions are crusted.
- Standard, Contact and Airborne precautions apply for cases of immunocompromised or **disseminated** shingles until all lesions are crusted.
- Children with **localised** shingles may be nursed in a single room or cohorted on most wards except where immunocompromised patients reside. Your nurse will be able to advise you.
- Children with **disseminated** shingles must be nursed in a N-class or 100% exhaust ventilation room. Your nurse can confirm if your room is N-class.
- Wash hands on **entering** and leaving the child's room with the chlorhexidine hand wash. Dry hands thoroughly and then apply 1% chlorhexidine and 70% alcohol hand rub.
- Visitors according to the medical team's discretion in consultation with Infection Prevention and Control.
- The child with shingles cannot attend the Starlight Room.
- The child with shingles cannot visit other inpatients.
- The child with localised shingles can attend the schoolroom or dining areas within the hospital if all of the lesions can be completely covered with a hydrocolloid dressing. This must be negotiated with the Infection Prevention and Control Team.

NSW Health Shingles Fact sheet for parents/carers

- https://www.health.nsw.gov.au/Infectious/factsheets/Pages/shingles.aspx

Shingles – Information for HCW

For Inpatient Management:

- Standard and Contact precautions apply for cases of **localised** shingles until all lesions are crusted for more than 24hrs.
- Standard, Contact and Airborne precautions apply for cases of **disseminated** shingles until all lesions are crusted for more than 24hrs.
- Children with **localised** shingles may be nursed in a single room or cohorted on any ward with the exceptions listed in Table 1 of this Policy.
- Children with **disseminated** shingles must be nursed in a N-class or 100% exhaust ventilation room.
- Perform hand hygiene on entering the child's room.
- On leaving the child's room perform hand hygiene with the chlorhexidine hand wash, dry hands thoroughly and then apply 1% chlorhexidine and 70% alcohol hand rub.
- Visitors according to the medical team's discretion in consultation with Infection Prevention and Control.
- The child with shingles cannot attend the Starlight Room.
- The child with shingles cannot visit other inpatients.
- The child with localised shingles can attend the schoolroom or dining areas within the hospital if all of the lesions can be completely covered with a hydrocolloid dressing. This must be negotiated with the Infection Control Team.

Health care workers:

- Staff with no immunity to varicella must not care for the child.
- All HCW must provide evidence to prove they have protection against varicella (this is undertaken at recruitment). Those non-immune will have a risk management plan in place discuss with Staff Health.
- HCW who have no immunological protection against varicella should be vaccinated.
- HCW who refuse vaccination must acknowledge this in writing.
- Unprotected HCW will be risk managed and must not work in areas where others are put at risk.
- Unprotected HCW who are exposed to shingles will be monitored by Staff Health and excluded from work if symptomatic. Exclusion from work will continue until all lesions are crusted.

For further information please contact Infection Prevention and Control:

- CHW - Ext 50534 / 52534. SCHN-CHW-InfectionPreventionAndControl@health.nsw.gov.au
- SCH – 0436 287 137 or Ext 21876/20643. SCHN-SCH-InfectionControl@health.nsw.gov.au

  Staff Health - CHW office 98453555; SCH office 93820758; Phone 0447462668, Email- SCHN-staffhealthandwellbeng@health.nsw.gov.au